

UTAH MEDICAID NURSING FACILITY
State Fiscal Year 2013
QUALITY IMPROVEMENT INCENTIVE (2)(iii) APPLICATION
Patient Bathing Improvements, Rule R414-504-4

This form and all supporting documentation must be postmarked or faxed on or before May 31, 2013

Facility Name: _____

Medicaid Provider I.D. _____ Administrator: _____

Please mark all that are complete:

- ☐ This facility has purchased Patient Bathing Improvements which may be one or more of the following:
- ☐ A new side-entry bathing system that allows the resident to enter the bathing system without having to step over or be lifted into the bathing area.
 - ☐ Heat lamps or warmers (e.g. blanket or towel)
 - ☐ Bariatric equipment (e.g. shower chair(s), shower gurney(s), etc.)
 - ☐ General improvements to the patient bathing/shower area(s)
- ☐ A detailed description of the patient bathing improvement purchased is attached.
- ☐ The bathing system was purchased by May 31, 2013.
- ☐ The bathing system was installed between July 1, 2011 and May 31, 2013.
- ☐ Proof of purchase that includes receipts and invoices, is also attached. This includes proof of payment, i.e. cancelled check(s), financial debt instrument, etc.

Qualifying facilities may receive up to \$110 per Medicaid Certified bed under this incentive (count as at 7/1/2012). This incentive is part of incentive (2). The maximum a facility may receive from all incentives in incentive (2) combined, is \$575.80 per Medicaid Certified bed (count as at 7/1/2012). Facilities will not receive more than was expended under this incentive.

Attach Spreadsheet for detail expenditures

Total Reimbursement Requested (should match spreadsheet): \$ _____

Please ensure that all the supporting documentation is included. Failure to include all of the above detailed information will prevent the facility from qualifying.

By submitting this application I certify that all of the above criteria have been met.

Administrator Signature: _____ Date: _____

Note: Division staff will not request additional information relating to this submission. Please be sure to include all necessary information in order to qualify. Fax to: 801-323-1595 <or> Mail instructions: <http://health.utah.gov/medicaid/stplan/longtermcare.htm>

For Medicaid use only:
Amount reimbursed

Date Paid